Approved POC on 3/2/11 AE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1774AGC	A. BUILDING _____ B. WING _____	01/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT LAS VEGAS	3025 E RUSSELL ROAD LAS VEGAS, NV 89120

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Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 1/6/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a grade of C. The facility is licensed for eighty-nine (89) Residential Facility for Group beds for elderly or disabled persons and sixteen (16) Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 97. Twenty resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors. The facility desires that this plan of correction be considered the facility's allegation of compliance.	
Y 105 SS=D	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.	Y 105 AE OK	**Y 105 Personnel File-Background Check** 1. Employee #9 had not renewed fingerprints after five years **I. HOW TO IDENTIFY OTHER EMPLOYEES** Employee files will be audited to identify which employees have worked for the community five years and longer. Tracking system will be implemented. **II. SYSTEMIC CHANGES** Tracking system will be implemented to identify employees who have worked five years and over. **III. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of employee records . DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing. RECEIVED FEB 2 6 2011 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA RECEIVED JAN 3 1 2011 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/31/11

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Y 105	Continued From Page 1 449.185, inclusive. This RULE: is not met as evidenced by: Based on record review and interview on 1/6/11, the facility failed to ensure 1 of 10 employees met background check requirements of NRS 449.176 to 449.188 (Employee #9 had not renewed fingerprints after five years). This was a repeat deficiency from the 1/30/09 and 1/12/10 State Licensure survey. Severity: 2 Scope: 1	Y 105	**Y 178 Health and Sanitation –Maintain Int/Ext** 1. Clothing articles observed behind dryer in memory care. **IV. HOW TO IDENTIFY OTHER RESIDENTS** Housekeeping and maintenance protocols will be monitored and enforced by Asset Manager. **V. SYSTEMIC CHANGES** Memory Care Director, Resident Care Director and Asset Manager will monitor housekeeping needs throughout community. **VI. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of housekeeping and maintenance needs. . DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing.	
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This RULE: is not met as evidenced by: Based on observation on 1/6/11, the facility failed to ensure the premises was clean and well maintained (Numerous clothing articles were observed in a pile behind the dryer in memory care providing an potential ignition source for a fire). Severity: 2 Scope 3	Y 178	**Y 225 Permits-Comply with NAC 446 on Food Service** a. Dented cans in dry storage room b. Person in charge of the kitchen at the time of inspection was not safety certified. c. Improper thawing methods d. Handling dirty dishes and then handling clean dishes prior to washing hands e. Kitchen staff drinking out of container in kitchen area f. No detectable sanitizer during final rinse cycle of the dish machine g. No detectable sanitizer in solution in sanitizer bucket h. Staff food stored in reach in refrigerator i. Vent on front of hood above the stove and grill soiled j. Soap dispenser not attached to wall	

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Y 178	Continued From Page 2	Y 178	k. The walls were damaged and the paint was chipping on the wall behind the steam table and hand sink in serving area l. One cabinet door in dining room fell off onto the floor when opened m. Pre spray hose in dish room had stretched, making it able to hand down into the liquid and food waste in garbage disposal **VII. HOW TO IDENTIFY OTHER RESIDENTS** Food service protocols will be monitored and enforced by Dining Services Director. **VIII. SYSTEMIC CHANGES** a. In-service for dented can protocol will be conducted b. Person in charge of kitchen will receive a Safe Serve Certification c. Proper thawing method in-service will be conducted d. Proper Sanitation Protocol in-service will be conducted j, k, l and m. Maintenance work orders in-service will be conducted and all repairs will be made **IX. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of food service and maintenance needs. DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing. **Y 393 Safety Requirements** 1. Facility failed to respond to auditory alarms **X. HOW TO IDENTIFY OTHER RESIDENTS** Staffing needs will be re assessed. In-service will be conducted with care staff to increase proper communication.	OK Accept 2/15/11
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 on Food Service NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This RULE: is not met as evidenced by: Based on observation, interview and record review on 1/6/11, the facility failed to ensure the kitchen complied with the standards of NAC 446. Findings include: 1 Critical Violations: a. There was a dented can of tomato soup and a very badly dented can of cream of corn soup on the rack in the dry storage room. b. The person-in-charge of the kitchen at the time of the inspection was not food safety certified.	Y 255		

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Y 255	Continued From Page 3 c. A package of raw beef was directly on top of packages of raw chicken in the same container during the thawing process. d. The person washing dishes was observed handling dirty dishes and not washing her hands before handling clean kitchenware and tableware. e. A foodhandler was observed taking gloves out of her pocket, putting them on, and then handling clean plates. f. The cook, who was the person-in-charge, was observed drinking from an open beverage container which had been placed on the food preparation table, and then immediately handling clean plates. g. There was no detectable sanitizer during the final rinse cycle of the dishmachine. 2. Cleaning and Sanitation Issues: a. There was no detectable sanitizer in the solution in which wiping cloths were stored in the kitchen, and there was a wet wiping cloth on the serving line with no sanitizer bucket in the serving area. b. Staff food was stored with resident food in the reach-in refrigerator on the serving line. c. The vent on the front of the hood above the stove and grill was soiled, and the oven and juice dispenser were soiled with food residue. 3. Equipment and Maintenance Issues: a. The soap dispenser was no longer attached	Y 255		

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Y 255	Continued From Page 4 to the wall at the handsink in the dishroom. b. The walls were damaged and the paint was chipping on the wall behind the steam table and the handsink in the serving area. c. One cabinet door in the dining room fell off onto the floor when it was opened. d. The pre-spray hose in the dishroom had stretched, making it able to hang down into the liquid and food waste in the garbage disposal. Severity 2: Scope: 3	Y 255		
Y 393 SS=F	449.226(4)(a)-(c) Safety Requirements NAC 449.226 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility. (b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility.	Y 393		

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Y 393	Continued From Page 5 This RULE: is not met as evidenced by: Based on observation and interview on 1/6/11, the facility failed to respond to auditory alarms for 3 of 3 sampled alarms activated (Bathroom #36, Whirlpool Room, Resident's pendent in Bedroom #25). The was a repeat deficiency from the 1/12/10 State Licensure Survey. Severity: 2 Scope: 3	Y 393 AE OK	**XI. SYSTEMIC CHANGES** Memory Care Director, Resident Care Director and Executive director will monitor respond times **XII. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of respond times. . DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing.	
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This RULE: is not met as evidenced by: Based on record review on 1/6/11, the facility failed to ensure that 6 of 20 residents received an annual physical (Resident #3, #4, #9, #13, #14 and #15 were all missing 2010 physicals). Severity: 2 Scope: 2	Y 859 AE OK	**Y 859 Periodic Physical Examination of a Resident** 1. Residents #3, #4, #9#13, #14, #15 had their annual physicals sent out to their physicians on 12/26/10. During survey the above resident's physicians had not responded with their patient's annual physicals. **XIII. HOW TO IDENTIFY OTHER RESIDENTS** Audit resident charts to determine who needs annual physicals and continue to use internal quality assurance program. **XIV. SYSTEMIC CHANGES** Memory Care Director, Resident Care Director and Executive Director will monitor annual physicals needed for residents. **XV. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of annual physicals for residents. . DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing. **Y 885 Medication/Destruction**	

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Y 885	Continued From Page 6	Y 885		
Y 885 SS=D	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This RULE: is not met as evidenced by: Based on observation and interview on 1/6/11, the facility failed to destroy medications after they were discontinued, had expired or after a resident had been transferred for 1 of 20 residents (Resident #6-Klor Con 10 milligram tablets, Lisinopril 10 milligrams tablets and Nitrendipine ER 30 milligrams tablets were found in the medication drawer and were not listed on the medication administration record). This was a repeat deficiency from the 9/8/09 and 1/12/10 State Licensure survey. Severity: 2 Scope: 1	Y 885 AE OK	RECEIVED FEB 16 2011 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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Y 895	Continued From Page 7	Y 895		
Y 895 SS=D	449.2744(1)(b)(1) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This RULE: is not met as evidenced by: Based on record review on 1/6/11, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 20 residents (Resident #7-Warfarin 2.5 milligrams: MAR stated to give 10 milligrams on Sunday, Tuesday and Thursday, medication container or blister pack stated to give 10 milligrams on Sunday and Tuesday and the physician order stated to give 10 milligrams on Sunday, Tuesday, Thursday and Saturday).	Y 895	1. Resident #6s medication was not destroyed after the resident's physician had discontinued it. **XVI. HOW TO IDENTIFY OTHER RESIDENTS** Medication carts will be audited to insure no other residents have discontinued medications in the cart. **XVII. SYSTEMIC CHANGES** Memory Care Director, Resident Care Director and Executive Director will monitor physician medication orders through a random quality assurance process. In-service will be conducted with medication technicians about following physician orders. **XVIII. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of medication protocols. . DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing. **Y 895 Medication/MAR** 1. Resident #7s medication order was not transcribed correctly to the electronic MAR. **XIX. HOW TO IDENTIFY OTHER RESIDENTS** Resident Care Director and/or designee will do an audit make sure physician orders are transcribed correctly to the electronic MARs. **XX. SYSTEMIC CHANGES** Memory Care Director, Resident Care Director and Executive Director will monitor electronic MAR. In-service will be conducted by the electronic MAR provider. In-service with Medication Technicians to insure that medications are being administered as prescribed by the physician. **XXI. MONITORING PROCESS** This process will be monitored by the Executive Director or designee by conducting on-going random review of electronic MAR.	

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Y 895	Continued From Page 8 Severity: 2 Scope: 1	Y 895	DATE COMPLETION This plan of correction will be completed by 02/24/11 and ongoing.	
Y 936 SS=D	449.2749(1)(e) Resident file-NRS 441A Tuberculosis NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This RULE: is not met as evidenced by: Based on record review on 1/6/11, the facility failed to ensure 1 of 20 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #19- missing the results of 2nd step TB test) which affected all residents. This was a repeat deficiency from the 1/30/09 and 1/12/10 State Licensure survey. Severity: 2 Scope: 1	Y 936	AE OK This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors. The facility desires that this plan of correction be considered the facility's allegation of compliance. **Y 936 449.2749 Resident File Tuberculosis** 1. Resident #19 did not have a 2nd step tb test **HOW TO IDENTIFY OTHER RESIDENTS** Resident files will be audited to identify that each resident has had a 2 step TB test. Tracking system will be used. **SYSTEMIC CHANGES** Tracking system will be used to ensure residents are Having their TB test done upon move in and annually. MONITORING PROCESS This process will be monitored by the Executive Director or designee by conducting on-going random review of residentrecords . DATE COMPLETION This plan of correction will be completed by 02/28/11 and ongoing. RECEIVED FEB 2 8 2011 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	